# Life & Times
# General practice after COVID-19:
## an introduction to our special series

COVID-19 has brought about unprecedented change within general practice, especially the large-scale switch from face-to-face consultation to teleconsultation. This was a necessary response to the very real potential for surgery sessions to become 'super-spreader events'. This would have not only increased the spread of COVID-19, but also reduced the ability of primary care to respond to the pandemic as healthcare staff inevitably became ill.

Most of us assumed that the changes would be short term. But we gradually realised that things would not go back as they were. When the pandemic eventually subsided it would leave behind some sort of 'new normal'.

Three months ago *BJGP Life* called for articles on the theme of general practice after COVID-19. What will our new normal look like? What *could* it look like, and how could we build it? In Life and Times this month we showcase some of these articles, published in *BJGP Life* in April.

So what conclusions can we draw from these contributions? Perhaps it will come as no surprise that these articles provide little consensus as to how we should go forward.

### THE TWO POLES

One theme is the need for a realistic review of the age-old 'good/fast/cheap' dilemma. (You can have any two, just not all three.) Just how much health care, of what quality, can be provided for the resources on offer? A call for realism and honesty in political debate — well, there's a new idea!

A simplistic analysis of the other articles (representative also of those that we have not been able to include) shows there is a spectrum of opinion about the direction of travel.

Some articles focus on the potential for modern technology to give alternatives to face-to-face consulting. For simple transactions patients may find remote consulting more accessible and convenient. And perhaps remote patient monitoring, or telemedicine, may at last live up to its potential. But it is perhaps ironic that most remote consultation has been done not as video consultation, where at least both can see the other's face, but as telephone consulting[1] — available for over a century.

***David Misselbrook***

The other pole of this spectrum highlights what we are losing in the retreat from face-to-face consultation. What about continuity of care? What about a personal doctor–patient relationship? What about trust? What about the doctor as a witness to, and interpreter of, the patient's lived experience of illness?

What these two poles illustrate is an inherent tension between the two aspects of medicine itself. Is the practice of medicine primarily transactional or relational?

A transactional model of medicine sees medicine as primarily biomedical in its focus. Patients need defined medical inputs. These can often be determined by algorithms and therefore may often be done more cheaply by clinicians other than doctors. The clinicians themselves are interchangeable — it is the defined intervention that matters.

A relational model of medicine sees biomedical interventions as occurring within complex, highly personal contexts requiring personalised judgements that go beyond biomedical algorithms. These will therefore depend on a deeper understanding of the patient, within their family and social setting, and over a longer timeframe. It is hard to see how such judgements could be made by a doctor, or accepted by a patient, without an established relationship of trust.

A transactional model of medicine may indeed be suitable if I am usually healthy with a strong internal locus of control and just need a sicknote, a repeat of a routine medication, or a limited one-off procedure or an emergency. The transactional model is beloved of politicians and managers — it makes the doctor an interchangeable cog who can often be sidelined altogether.

A relational model of medicine seems more suited to dealing with chronic disease and multimorbidity, especially in vulnerable populations who may have less of an internal locus of control. The relational model is hard for politicians and managers to understand or even see, and certainly does not fit in well with managerial models.

Like most things in life, we need to embrace a well-chosen mid-point between two extremes. Good medicine encompasses the transactional (we do things to people that are usually predictable), but this should be nested within an ongoing relationship of understanding and trust.

We need to build the future together, and reflecting on this month's *Life & Times* is a good place to start. COVID-19 has changed so much. But some things in medicine should not change.

**David Misselbrook,**
Deputy Editor, *BJGP*.
**Email: DMisselbrook@rcsi-mub.com**

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### REFERENCE

1. Murphy M, Scott LJ, Salisbury C, *et al.* Implementation of remote consulting in UK primary care following the COVID-19 pandemic: a mixed-methods longitudinal study. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/BJGP.2020.0948.